

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3337 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03296

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Barnett Co.</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Star Route 40</u> c. LENGTH OF STAY IN lb <u>Instant</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Barnett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Frostburg</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Earl</u> First <u>Harvey</u> Middle <u>Caton</u> Last				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>5</u> Year <u>1960</u>			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>March 1-1939</u> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>21</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Seabold Trucking</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Finzel Road</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			
<b>13. FATHER'S NAME</b> <u>Earl C. Caton</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Nannie Albright</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b> <u>202-34-1723</u>		<b>17. INFORMANT</b> <u>Mrs. Pearl Garlitz</u> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>816X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemothorax, Abdominal hemorrhage</u> DUE TO (c) <u>Ruptured Lung, right, Ruptured liver</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>15 min</u> <u>15 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of right arm</u>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto collision</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>9:00 a.m. Mar. 5 19 60</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Rt. #40</u>		<b>20f. (City or town)</b> <u>6mi. W. of Frostburg, All. Md.</u> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>James H. Feaster, Jr.</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>James H. Feaster, Jr.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>3-5-60</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3/9-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Johnson</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Barnett Co.</u> (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph R. D. Frostburg</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DATE MAR 8 '60</u>			
<b>ADDRESS</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGY		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL		21. SIGNATURE OF CREMATION	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3330 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03297

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>			c. LENGTH OF STAY IN 1b <u>minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Oakland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Liberty St. Ext.</u>				d. STREET ADDRESS <u>Liberty St. Ext.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Collins</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 3, 1876</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>stone mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Penn. chance, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Collins</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Bosley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-32-3066</u>		17. INFORMANT <u>Priscilla Shaffer</u> Address <u>Oakland, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		3-9-60	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnich Funeral Home</u>				ADDRESS <u>Oakland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3338 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03298

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Swanton</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>---</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Swanton</b> d. STREET ADDRESS <b>---</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Beatrice L. McRobie Custer</b>		4. DATE OF DEATH Month <b>March</b> Day <b>24</b> , Year <b>1960</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1899</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John W. McRobie</b>			14. MOTHER'S MAIDEN NAME <b>Stella Rodeheaver</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-36-9411</b>		17. INFORMANT <b>Ray R. Custer</b> Address <b>Swanton, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Acute</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		<b>3-25-60</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>North Glade Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Swanton, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton</b>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3331

## CERTIFICATE OF DEATH

03299

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>GARRETT COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>W. VA.</u> b. COUNTY <u>TUCKER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND, MARYLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIS,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>85X-3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AGNES BELL EVANS</u>		4. DATE OF DEATH Month Day Year <u>MARCH 6 19 60</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 16 XXXXXX, 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MAYSVILLE, W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOE MC GRAW</u>		14. MOTHER'S MAIDEN NAME <u>PEARL EVERLY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Homer Evans</u>		Address <u>Davis, W.Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>199. 2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tubercle, Parenchymal, Secondary,</u> DUE TO <u>to a.</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>2 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November, 1959</u> , to <u>March 6, 1960</u> , that I last saw the deceased alive on <u>March 6, 1960</u> , and that death occurred at <u>7:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred Owen, Jr.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>March 8, 1960</u>	
PHYSICIAN'S NAME (Type) <u>DR. ALFRED OWEN</u>		<u>AIRCRA, W. VA.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/9/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Davis</u>	22d. LOCATION (City, town, or county) (State) <u>Davis, W.Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne C. Spiggle</u>		24a. REC'D BY REGISTRAR <u>DAVIS, W. VA.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>		DATE <u>MAR 10 '60</u>	

THE UNIVERSITY OF CHICAGO PRESS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3339

## CERTIFICATE OF DEATH

03300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GAYLETT MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>Galett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Friendsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Friendsville Md</b>	
c. LENGTH OF STAY IN 1b <b>all life</b>		d. STREET ADDRESS <b>RFD.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARTIN - FALKNER</b>		4. DATE OF DEATH <b>Mar 17 1960</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 14 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lumber Ind.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>	
11. BIRTHPLACE (State or foreign country) <b>Ira</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Samuel Falkner</b>		14. MOTHER'S MAIDEN NAME <b>Martha Friend</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>236-01-9285</b>	
17. INFORMANT <b>Mrs Martin Falkner - Friendsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY Arteriosclerosis</b> (c) <b>GENERALIZED Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA of Prostate</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August, 1959</b> , to <b>Dec, 1959</b> , that I last saw the deceased alive on <b>Dec, 1959</b> , and that death occurred at <b>12:02 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Pedro Rivera</b>		ADDRESS (Street, city or town, state) <b>Friendsville, MD</b> DATE SIGNED <b>Mar 13-60</b>	
PHYSICIAN'S NAME (Type) <b>PEDRO RIVERA</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Mar 15 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Blooming Rose Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Friendsville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Rodakaver</b>		ADDRESS <b>Markleysburg Pa</b>	
24a. REC'D BY REGISTRAR <b>MAR 17 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

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15-11-15

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.  
FURNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

3340

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03301

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>PRESTON</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park, Md.</b>		c. LENGTH OF STAY IN 1b <b>Minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EGLON</b> <b>85X-3</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>T.</b> Last <b>FIKE</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>11</b> Year <b>1960</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 15, 1900</b>			
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman &amp; Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical Supplies</b>		11. BIRTHPLACE (State or foreign country) <b>EGLON, WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>JONAS FIKE</b>				14. MOTHER'S MAIDEN NAME <b>DELLA HAMSTEADZ</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>233-16-9485</b>		17. INFORMANT <b>J. ROGER FIKE, OAKLAND, MARYLAND.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS</b> (c) <b>***</b> DUE TO stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3-11-60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>3/14/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Eglon Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Eglon, West Virginia.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.R. Watson</i> <b>P.R. WATSON, F.D. LICENSE A 7220</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 16 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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DECEASED'S NAME LAST FIRST MIDDLE _____		SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
AGE YEARS MONTHS DAYS _____		DATE OF DEATH MONTH DAY YEAR _____	
PLACE OF DEATH _____		CITY _____	
COUNTY _____		STATE _____	
OCCASION OF DEATH _____			
CAUSE OF DEATH _____			
MANNER OF DEATH _____			
SIGNATURE OF MEDICAL EXAMINER _____			
TITLE OF MEDICAL EXAMINER _____			
SIGNATURE OF WITNESS _____			
TITLE OF WITNESS _____			
SIGNATURE OF SECOND WITNESS _____			
TITLE OF SECOND WITNESS _____			
SIGNATURE OF THIRD WITNESS _____			
TITLE OF THIRD WITNESS _____			
SIGNATURE OF FOURTH WITNESS _____			
TITLE OF FOURTH WITNESS _____			
SIGNATURE OF FIFTH WITNESS _____			
TITLE OF FIFTH WITNESS _____			
SIGNATURE OF SIXTH WITNESS _____			
TITLE OF SIXTH WITNESS _____			
SIGNATURE OF SEVENTH WITNESS _____			
TITLE OF SEVENTH WITNESS _____			
SIGNATURE OF EIGHTH WITNESS _____			
TITLE OF EIGHTH WITNESS _____			
SIGNATURE OF NINTH WITNESS _____			
TITLE OF NINTH WITNESS _____			
SIGNATURE OF TENTH WITNESS _____			
TITLE OF TENTH WITNESS _____			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03302

3341

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BARRETT</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Friendsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MD</b>		
c. LENGTH OF STAY IN 1b <b>Most of life</b>		d. STREET ADDRESS <b>R.F.D.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ALICE - FRIEND - FRAZEE</b>		4. DATE OF DEATH <b>Mar 18 1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 4 - 1873</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Scott Friend</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Raughter</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		
17. INFORMANT <b>Agnes Frazee - Friendsville MD</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>Old Age</b>				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>JAN</b> , 19 <b>59</b> to <b>MARCH</b> , 1960, that I last saw the deceased alive on <b>MARCH</b> , 1960, and that death occurred at <b>7:20 P.</b> M, from the causes and on the date stated above.				
ACTUAL SIGNATURE <b>Pedro Rivera</b>		ADDRESS (Street, city or town, state) <b>Friendsville, MD</b> DATE SIGNED <b>Mar 1960</b>		
PHYSICIAN'S NAME (Type) <b>PEDRO RIVERA</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 21 - 1960</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Addison Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Addison Pa.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Rodakauer - Markleysburg</b>		ADDRESS <b>Pa</b>		
24a. REC'D BY REGISTRAR <b>DATE MAR 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>		



1891-1900  
 1901-1910  
 1911-1920  
 1921-1930  
 1931-1940  
 1941-1950  
 1951-1960  
 1961-1970  
 1971-1980  
 1981-1990  
 1991-2000  
 2001-2010  
 2011-2020

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PERO RIVERA

March 20

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March 20

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GENERAL AND ARTIFICIAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3342

## CERTIFICATE OF DEATH

03303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Friendsville Md</b>			
c. LENGTH OF STAY IN 1b <b>all life</b>				d. STREET ADDRESS <b>R.F.D. 2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Friendsville Md</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HAROLD - DAVID - FRIEND</b>				4. DATE OF DEATH <b>MAR - 1 - 1960</b>			
5. SEX <b>M.</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 26 - 1889</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>agriculture</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>	
13. FATHER'S NAME <b>David H. Friend</b>				14. MOTHER'S MAIDEN NAME <b>Mary Gary</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b> (If yes, give war or dates of service) <b>none</b>				16. SOCIAL SECURITY NO. <b>214-24-2274</b>			
17. INFORMANT <b>Mrs. Ruth Friend</b>				Address <b>Friendsville Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Ventricular Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <b>Sept</b> , 1958, to <b>Feb 29</b> , 1960, that I last saw the deceased alive on <b>2-29</b> , 1960, and that death occurred at <b>8:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Pedro Rivera</b>				ADDRESS (Street, city or town, state) <b>Friendsville, Md</b>			
PHYSICIAN'S NAME (Type) <b>PEDRO RIVERA</b>				DATE SIGNED <b>Mar 2 - 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 3 - 60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sand Spring</b>		22d. LOCATION (City, town, or county) (State) <b>Friendsville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Rodenhauer</b>				ADDRESS <b>Markleysburg Pa</b>		24a. REC'D BY REGISTRAR <b>MAR 7 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

NAME: GARRETT, RALPH  
 RACE: White  
 SEX: Male  
 AGE: 71  
 DATE OF BIRTH: Feb. 1881  
 DATE OF DEATH: MAR. 1 - 1950

OCCUPATION: Farmer  
 PLACE OF BIRTH: Maryland  
 PLACE OF DEATH: Baltimore, Maryland  
 CAUSE OF DEATH: Heart Failure  
 MEDICAL HISTORY: None

SIGNATURE OF PHYSICIAN: [Signature]  
 SIGNATURE OF CORONER: [Signature]  
 SIGNATURE OF WITNESSES: [Signatures]

REMARKS: [Handwritten notes]

3332

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>				c. LENGTH OF STAY IN 1b <b>54 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Oak Street</b>				d. STREET ADDRESS <b>Oak Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Gemmell</b> Last <b>Gemmell</b>				4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 26, 1886</b>	
9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Florist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Green House</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME (First name not known) <b>Gemmell</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Huthhinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-10-7707</b>		17. INFORMANT <b>Teresa Welling</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>150X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Primary Carcinoma of Esophagus</b> DUE TO (c) <b>Unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 20, 1959</b> to <b>March 10, 1960</b> , that I last saw the deceased alive on <b>March 6, 1960</b> , and that death occurred at <b>1:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.				ADDRESS (Street, city or town, state) <b>77 Oak St. Oakland, Md.</b>			
DATE SIGNED <b>11 Mar 60</b>							
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b>				Address <b>Oakland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/13/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton</b>				ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE <b>Colleen S. Kline</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03305

Reg. Dist. No.

3343

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRANTSVILLE, MD</u>		c. LENGTH OF STAY IN 1b <u>20 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRANTSVILLE, MD</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>OLIVE</u> Middle <u>DORTHEA</u> Last <u>HOOVER</u>				4. DATE OF DEATH Month <u>MAR.</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 8 1908</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TELEPHONE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SPRINGS MUTUAL</u>		11. BIRTHPLACE (State or foreign country) <u>CONNELLSVILLE, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE YOMMER</u>				14. MOTHER'S MAIDEN NAME <u>IDA BITTINGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-25-9691</u>		17. INFORMANT <u>Maile Hoover, 9203 Orbiter Rd, Balt, 14 MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feather</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-27-60</u>	
EXAMINER'S NAME (Type) <u>JAMES H FEATHER, JR</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/31/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GRANTSVILLE</u>		22d. LOCATION (City, town, or county) <u>GRANTSVILLE GARRETT CO MD</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman, Grantsville, Md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03306

3333

## CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>13 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES E. KISNER</b>		4. DATE OF DEATH <b>MARCH 11 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 22, 1888</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINER</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mines</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JACOB KISNER</b>		14. MOTHER'S MAIDEN NAME <b>JAMIMA ENLOW</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-01-4891</b>	
17. INFORMANT <b>CHARLES E. KISNER</b>		Address <b>ROUTE # 2 DEER PARK, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>Generalized</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Nephritis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-26</b> , 19 <b>60</b> , to <b>3-11</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3-10</b> , 19 <b>60</b> , and that death occurred at <b>2:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>58 2nd St Oakview 3-11-60</b> DATE SIGNED <b>3-11-60</b> ACTUAL SIGNATURE <b>Dr. James H. Feaster Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>DR. JAMES H. FEASTER JR.</b> <b>OAKLAND, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>3/13/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Nethken Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elk Garden, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>He. Leighton</b> ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 14 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			



3344

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL GRANTSVILLE</u>				c. LENGTH OF STAY IN 1b <u>3 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GOODWILL MENNONITE HOME, GRANTSVILLE MD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>KLOTZ</u> Last <u>KLOTZ</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 23 1869</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>90</u> Days <u>90</u> Hours <u>90</u> Min.		IF UNDER 24 HRS. Months <u>90</u> Days <u>90</u> Hours <u>90</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BROTHERS HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>GRANTSVILLE, MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>CHRIST KLOTZ</u>				14. MOTHER'S MAIDEN NAME <u>MARY POPE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>20 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 1, 1960</u> to <u>March 2, 1960</u> that I last saw the deceased alive on <u>March 1, 1960</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. Paige Strong</u> M.D.				ADDRESS (Street, city or town, state) <u>Grantsville, Md.</u> DATE SIGNED <u>3/2/60</u>			
PHYSICIAN'S NAME (Type) <u>A. PAIGE STRONG</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/4/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ACCIDENT</u>		22d. LOCATION (City, town, or county) (State) <u>ACCIDENT GARRETT Co, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u> ADDRESS <u>GRANTSVILLE, MD</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03308

Reg. Dist. No.

3334

1. PLACE OF DEATH a. COUNTY <b>Preston</b> <i>Garrett</i> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Preston</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rowlesburg</b>			<b>85x-3</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS <b>Wilson Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Barbara</b> Middle <b>Dianne</b> Last <b>Lewis</b>				4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 20, 1954</b>		9. AGE (In years last birthday) <b>6</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>29</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grade School</b>		11. BIRTHPLACE (State or foreign country) <b>Terra Alta, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harley Melvin Lewis</b>				14. MOTHER'S MAIDEN NAME <b>Elouise Virginia Yonker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Elouise V. Lewis, Rowlesburg, W.Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lower Nephron Nephrosis; Anasarca; Hydrothorax; Ascites</b> DUE TO <b>916.0</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>3rd &amp; 4th degree burns (approx. 50% of body)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atelectasis; terminal, due to aspiration of stomach contents</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Clothing caught fire from gas heating stove.</b>					
20c. TIME OF INJURY Month, Day, Year <b>8:45 a.m. 3/27/60 19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Rowlesburg, Preston, West Va.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feister Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James H. Feister Jr. M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 29, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal &amp; Burial</b>		22b. DATE THEREOF <b>4/2/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Terra Alta Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Terra Alta, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William</i> ADDRESS <b>Terra Alta, West Virginia. Md. F.D. No. A 7220</b>				24a. REC'D BY REGISTRAR DATE <b>APR 1 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

# MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		CITY [Illegible]	
COUNTY [Illegible]		STATE [Illegible]	
OCCUPATION [Illegible]			
CAUSE OF DEATH [Illegible]			
MANNER OF DEATH [Illegible]			
SIGNATURE OF MEDICAL EXAMINER [Illegible]			
TITLE OF MEDICAL EXAMINER [Illegible]			
SIGNATURE OF WITNESS [Illegible]			
TITLE OF WITNESS [Illegible]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3335

## CERTIFICATE OF DEATH

03309

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT COUNTY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY <b>PRESTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND, MARYLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STAR ROUTE TERRA ALTA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>85X-3</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>DAVID</b> Last <b>MESSINGER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 15, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>TERRA ALTA, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>SAMUEL MESSINGER</b>		14. MOTHER'S MAIDEN NAME <b>BRAHAM, Mary</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles W. Messenger, Terra Alta, W.Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation - Cardiac Standstill - 5 minutes</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b> (c) <b>Arteriosclerotic Cardio Vascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thrombosis, Chronic</b> INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct</b> , 19 <b>59</b> , to <b>March 6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>March 6</b> , 19 <b>60</b> , and that death occurred at <b>3:25 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak St., Oakland, Md. 6 Mar 60</b>	
PHYSICIAN'S NAME (Type) <b>DR. HERBERT LEIGHTON</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 9, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Maplewood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkins, West Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William F. D. License A 7220</b>		ADDRESS <b>Terra Alta, West Virginia.</b>	
24a. REC'D BY REGISTRAR <b>MAR 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	





3345

## CERTIFICATE OF DEATH

03310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>GARRETT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL GRANTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>HENRY</u> Last <u>POLEMAN</u>		4. DATE OF DEATH Month <u>MAR.</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 21/1869</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER-RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>GARRETT Co, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HENRY POLEMAN</u>		14. MOTHER'S MAIDEN NAME <u>CHRISTINA CHRISTNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Lawrence Poleman, RD, Salisbury Pa</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>10 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>58</u> , to <u>March 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 1</u> , 19 <u>60</u> , and that death occurred at <u>12:57 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Paige Strong</u> M.D.		ADDRESS (Street, city or town, state) <u>Grantsville, Md.</u> DATE SIGNED <u>3/4/60</u>	
PHYSICIAN'S NAME (Type) <u>A. Paige Strong</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT ZION</u>	22d. LOCATION (City, town, or county) (State) <u>STAR ROUTE FROSTBURG, GARRETT Co MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don J. Newman, Grantsville, Md</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 10 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03311

3345

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Swanton</b> c. LENGTH OF STAY IN 1b <b>68 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5 Mi. S E Swanton</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Swanton</b> d. STREET ADDRESS <b>5 Mi. S E Swanton</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Rhodes</b>				4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 13, 1891</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Soft Coal Mines</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Andrew Jackson Rhodes</b>				14. MOTHER'S MAIDEN NAME <b>Emily Bray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>WW #1</b>				16. SOCIAL SECURITY NO. <b>213-18-2907</b>			
17. INFORMANT <b>Dorsey Paugh</b> Address <b>R D #1 Swanton, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation, acute</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, moderate</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James H. Feaster Jr.</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James H. Feaster Jr., M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/8/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Garrett County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>He. Lighton</b> ADDRESS <b>Oakland, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]	
MARITAL STATUS [REDACTED]		CAUSE OF DEATH [REDACTED]	
MEDICAL HISTORY [REDACTED]		PRESENT ILLNESS [REDACTED]	
PHYSICIAN'S SIGNATURE [REDACTED]		MEDICAL EXAMINER'S SIGNATURE [REDACTED]	
DATE OF EXAMINATION [REDACTED]		PLACE OF EXAMINATION [REDACTED]	
TIME OF EXAMINATION [REDACTED]		TIME OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		PLACE OF BURIAL [REDACTED]	
NAME OF FUNERAL HOME [REDACTED]		NAME OF BURIAL PLACE [REDACTED]	
NAME OF NEXT OF KIN [REDACTED]		NAME OF PERSON TO BE NOTIFIED [REDACTED]	
ADDRESS OF NEXT OF KIN [REDACTED]		ADDRESS OF PERSON TO BE NOTIFIED [REDACTED]	
CITY OF NEXT OF KIN [REDACTED]		CITY OF PERSON TO BE NOTIFIED [REDACTED]	
STATE OF NEXT OF KIN [REDACTED]		STATE OF PERSON TO BE NOTIFIED [REDACTED]	
COUNTY OF NEXT OF KIN [REDACTED]		COUNTY OF PERSON TO BE NOTIFIED [REDACTED]	
ZIP CODE OF NEXT OF KIN [REDACTED]		ZIP CODE OF PERSON TO BE NOTIFIED [REDACTED]	
SIGNATURE OF MEDICAL EXAMINER [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
DATE OF SIGNATURE [REDACTED]		DATE OF SIGNATURE [REDACTED]	
PLACE OF SIGNATURE [REDACTED]		PLACE OF SIGNATURE [REDACTED]	
NAME OF MEDICAL EXAMINER [REDACTED]		NAME OF PHYSICIAN [REDACTED]	
ADDRESS OF MEDICAL EXAMINER [REDACTED]		ADDRESS OF PHYSICIAN [REDACTED]	
CITY OF MEDICAL EXAMINER [REDACTED]		CITY OF PHYSICIAN [REDACTED]	
STATE OF MEDICAL EXAMINER [REDACTED]		STATE OF PHYSICIAN [REDACTED]	
COUNTY OF MEDICAL EXAMINER [REDACTED]		COUNTY OF PHYSICIAN [REDACTED]	
ZIP CODE OF MEDICAL EXAMINER [REDACTED]		ZIP CODE OF PHYSICIAN [REDACTED]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)  
5M 9/55

3347

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oakland,</b> c. LENGTH OF STAY IN 1b <b>55 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R. D. 2, near Red House</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Oakland,</b> d. STREET ADDRESS <b>R D #2, near Red House</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harman</b> Middle <b>Casper</b> Last <b>Rolf</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2,</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1904</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John W. Rolf</b>	
14. MOTHER'S MAIDEN NAME <b>Lydia Blamble</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>212-24-2420</b>		17. INFORMANT <b>Mrs. Harman Rolf</b> Address <b>R D 2, Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b> DUE TO (b) <b>912.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Farm tractor upset on slippery ground and pinned head</b>	
20c. TIME OF INJURY Month, Day, Year <b>2-2-60</b> Hour <b>1</b> <b>X</b> P.M. <b>11</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>	20f. (City or town) <b>Rural Oakland Garr. Md.</b> (State) <b></b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>James H. Feaster Jr.</b>		DATE SIGNED <b>2-3-60</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster Jr., M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/5/1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Red House Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Garrett County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>	

MEDICAL CERTIFICATION

11

2



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

334

FILE NO.

NAME

AGE

SEX

DATE OF DEATH

RESIDENCE

CAUSE OF DEATH

DATE OF EXAMINATION

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3348

CERTIFICATE OF DEATH

Reg. Dist. No.

03313

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FRIENDSVILLE</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <b>1</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>EDWARD</b> Last <b>SWAUGER</b>				4. DATE OF DEATH Month <b>MAR.</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 20, 1881</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER-RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (State or foreign country) <b>BITTINGER, GARRETT CO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>SAMUEL SWAUGER</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA HARMON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-03-3804</b>		INFORMANT Address <b>Mrs. Edna Livingood Friendsville Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b> <b>610x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypostatic Pneumonitis</b> (c) <b>Prostration due to Aging.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN</b> , 1960, to <b>FEB 29</b> , 1960, that I last saw the deceased alive on <b>FEB 29</b> , 1960, and that death occurred at <b>1230 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Pedro Rivera</b>				ADDRESS (Street, city or town, state) <b>Friendsville</b>			
PHYSICIAN'S NAME (Type) <b>PEDRO RIVERA</b>				DATE <b>3-2-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/3/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GRANTSVILLE</b>		22d. LOCATION (City, town, or county) (State) <b>GRANTSVILLE GARRETT CO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don J. Newman</b>				ADDRESS <b>Grantsville Md</b>		24a. REC'D BY REGISTRAR <b>MAR 10 60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

MEDICAL CERTIFICATION

STATE OF MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BOSTON  
1912

CARROLL STANTON FARRIS

Heart at the  
Post-mortem July 10, 1912

For the purpose of the above mentioned

Dr. R. A. FARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3336  
CERTIFICATE OF DEATH

03314

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCoole</u> 01X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cuplett Nursing Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>M. Thompson</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/22/1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hardy County, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Newhouse</u>		14. MOTHER'S MAIDEN NAME <u>(unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT <u>Mr. Emory Thompson</u>		Address <u>McCoole, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Stroke</u> DUE TO (c) <u>Change</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Melancholia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1</u> , 19 <u>59</u> , to <u>March 16</u> 19 <u>60</u> , that I last saw the deceased alive on <u>March 14</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. J. Baumgartner</u> M.D.		ADDRESS (Street, city or town, state) <u>254 Cedar St Oakland Md</u>	
DATE SIGNED <u>3/18/60</u>			
PHYSICIAN'S NAME (Type) <u>E. J. BAUMGARTNER M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Petersburg, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Blaine Shaffer</u>		ADDRESS <u>Petersburg, W. Va.</u>	
24a. REC'D BY REGISTRAR <u>APR 4 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





3349

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GRANTSVILLE</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>OLIVE</b> Middle <b>MYRTLE</b> Last <b>ZELLER</b>		4. DATE OF DEATH Month <b>MAR.</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 30, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>GROVE CITY, PA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>JOHN A. BARR</b>		14. MOTHER'S MAIDEN NAME <b>FIRST NAME UNKNOWN WALLS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Charles Zeller, Grantsville Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>5 years</b>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 1958</b> to <b>March 12, 1960</b> that I last saw the deceased alive on <b>March 9, 1960</b> , and that death occurred at <b>3:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Grantsville</b> DATE SIGNED <b>3/11/60</b>			
ACTUAL SIGNATURE <b>A. Paige Strong</b> M.D. <b>Grantsville</b>		DATE SIGNED <b>3/11/60</b>	
PHYSICIAN'S NAME (Type) <b>A PAIGE STRONG</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/12/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEMORIAL</b>	22d. LOCATION (City, town, or county) (State) <b>FROSTBURG ALLEGANY MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don J. Newman, Grantsville, Md</b>		24a. REC'D BY REGISTRAR <b>MAR 14 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Charles L. Kline</b>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10312

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of attending physician: \_\_\_\_\_

11. Signature of medical examiner: \_\_\_\_\_

12. Signature of registrar: \_\_\_\_\_

13. Date of filing: \_\_\_\_\_

14. File number: \_\_\_\_\_